



Texas Department of Insurance

Division of Workers' Comp

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SOUTHWEST FRWY, SUITE 2200
HOUSTON TX 77027

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-08-6092-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Requestor submits that a fair and reasonable rate for surgeries performed on this employee are the usual and customary charges incurred. The carrier paid a total of \$1,612.26 on this surgery. Requestor is owed an additional \$26,779.99 on this surgery, plus interest."

"Memorial Hermann Hospital System does not agree to accept \$6,403.62 as settlement in full of their outstanding charges."

Amount in Dispute: \$26,779.99

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual is willing to enter into a settlement agreement with the requestor and pay an additional \$6,403.62 as payment in full, in return the requestor to withdraw its request for dispute resolution. Payment to the requestor will follow under separate cover."

Response Submitted by: Linda Estrada, Texas Mutual Insurance Co., 6210 East Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 7, 2007	Outpatient Services	\$26,779.99	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. This request for medical fee dispute resolution was received by the Division on June 5, 2008.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC- W1-Workers Compensation state fee schedule adjustment.
 - CAC-W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
 - 426-Reimbursed to fair and reasonable.
 - 713, 894-Fair and reasonable reimbursement for the entire bill is made on the 'O/R Service' line item.
 - 719-Reimbursed at carrier's fair & reasonable; cost data unavailable for facility. Additional payment may be considered if data submitted.
 - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
 - CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
 - 891-The insurance company is reducing or denying payment after reconsideration.

Findings

1. 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "a position statement of the disputed issue(s) that shall include"... "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).
2. 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
 - The requestor's position statement asserts that "Requestor submits that a fair and reasonable rate for surgeries performed on this employee are the usual and customary charges incurred. The carrier paid a total of \$1,612.26 on this surgery. Requestor is owed an additional \$26,779.99 on this surgery, plus interest."
 - The requestor does not discuss or explain how payment of \$26,779.99 would result in a fair and reasonable reimbursement.
 - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
 - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
 - The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:
 "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also

provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.”

- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	<u>9/22/2011</u> Date
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_____ Signature	_____ Medical Fee Dispute Resolution Manager	<u>9/22/2011</u> Date
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YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.